Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005002	A. BUILDING _____ B. WING _____	08/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST HOSPITALS INC	600 GRANT ST GARY, IN 46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit is for two (2) State hospital complaint investigations. Complaint: #IN00086824: Substantiated; no deficiencies related to allegations cited. #IN00084790: Unsubstantiated; lack of sufficient evidence Survey Date: 08/08/11 Facility # 005002 Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor Methodist Hospitals, Inc. is in compliance with 410 IAC 15-1.5-5, Physician services and 410 IAC 15-1.5-6, Nursing services, Indiana Hospital Licensure Rules. QA: claughlin 09/02/11	S 000		